
Last Name First Name MI

Patient SS#: _____

Date of Birth: ____/____/____

**PATIENT AUTHORIZATION
to Permit Use and Disclosure of
Health Information**

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I authorize _____
[1] Person or class of persons authorized to use or disclose the information
to use or disclose to _____

[2] Person or class of persons to whom use or disclosure would be made
the following protected health information (identify the information in a specific and meaningful fashion):

The purpose of the use or disclosure is [3] (describe each purpose of the requested use or disclosure):

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in

_____'s
[4] Name of covered entity
Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that

[4] Name of covered entity

cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. [5]

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon _____
[6] Date or event that relates to the patient or the purpose of the use or disclosure

Signature of patient **OR** authorized representative

Date

Please print name of patient or authorized representative who signed above

[7] Please explain representative's authority to act on behalf of the patient: _____

Last Name First Name MI

Patient SS#: _____

Date of Birth: ____/____/____

Departamento de Salud y Servicios Sociales de Carolina del Norte
Enfermería de Salud Pública

**AUTORIZACION DEL PACIENTE
PARA PERMITIR EL USO Y DIVULGACION
DE INFORMACION DE SALUD**

Yo soy el paciente mencionado anteriormente o el representante legal de dicho paciente.

Firmando esta planilla, autorizo a _____
[1] *Persona o clase de personas autorizadas a usar o divulgar la información*

A usar o divulgar a _____
[2] *Persona o clase de personas a quien se les suministrará el uso o divulgación*
la siguiente información de salud protegida (*identifique la información de una forma clara y específica*):

El propósito de esta divulgación es [3] (*describir cada propósito del solicitado uso o divulgación*):

Yo entiendo que, con ciertas excepciones, yo tengo el derecho en cualquier momento de anular esta Autorización. Si quisiera anular esta autorización, lo debo hacer por escrito. El proceso a seguir para anular esta autorización, así como las excepciones a mi derecho de anularlo, están explicadas en el documento "Notificación de Prácticas Privadas" de la entidad

[4] *Nombre de la Entidad*
Una copia de dicho documento se me ha sido entregado anteriormente.

Yo entiendo que puedo negarme a firmar esta autorización. También entiendo que la Entidad

[4] *Nombre de la Entidad*

no puede negarse a proveerme tratamiento, pago o inscripción en un plan de salud, o de quitarme el derecho a beneficios porque me niegue a firmar esta Autorización. [5]

Yo entiendo que, una vez que la información ha sido divulgada basada en esta Autorización, es posible que deje de estar protegida por la ley federal de privacidad médica y que pudiera ser divulgada de nuevo por la persona o agencia que la reciba.

Esta autorización vence automáticamente el _____
[6] *Fecha o evento relacionado con el paciente o propósito del uso o divulgación*

Firma del Paciente o Representante Autorizado

Fecha

Nombre (en letra de imprenta) del Paciente o Representante Autorizado que firmó planilla

[7] *Favor explique la autoridad que tiene el Representante para actuar en nombre del Paciente:* _____

**PATIENT AUTHORIZATION
to Permit Use and Disclosure of Health Information (DHHS #4056)**

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R. 164.508(c).

If the authorization is obtained to use or disclose information for marketing and the marketing involves direct or indirect payment to the health care provider from a third party, the authorization must state that such remuneration is involved.

- | | |
|--|--|
| [1] Person or class of persons authorized to use or disclose the information | Indicate who may release (eg., _____ County Health Department staff). |
| [2] Person or class of persons to whom use or disclosure would be made | Indicate by whom the information may be used or to whom it may be disclosed (e.g., UNC-CH School of Public Health). |
| [3] Purpose of use or disclosure | Describe why the information may be used or disclosed (e.g., research). The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose. |
| [4] Name of covered entity | The local health department. |
| [5] NOTE: The federal privacy law permits a health care provider, in certain limited circumstances, to condition the provision of health care on obtaining an authorization. For example, a health care provider may condition the provision of health care that is solely for the purpose of creating information for disclosure to a third party on an authorization permitting such disclosure. Where the privacy rule permits the conditioning of services on receipt of an authorization and <i>the health care provider chooses to make treatment conditional on the patient providing an authorization</i> , then the sentence in this form regarding the conditioning of the authorization must be modified to explain what the condition is and the consequences to the patient of a refusal to sign the authorization. | |
| [6] Date or event that relates to the patient or the purpose of the use or disclosure | Indicate specific date or event after which authorization is no longer valid (e.g., MM/DD/YY or “end of research study”). “None” is acceptable if the authorization is for the creation and maintenance of a research database or research repository. |
| [7] Explain representative’s authority to act on behalf of the patient | Identify source of authority for serving as patient representative (e.g., parent or legal guardian). |